

# Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 14 YEARS

## TO BE FILLED IN BY OFFICE STAFF:

Last Name		First Name		AHCCCS ID		D.O.B.		Age (Years)	
Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name			

## TO BE FILLED IN BY PROVIDER

### HISTORY INITIAL/INTERVAL

Comments Menarche: \_\_\_\_\_ LMP: \_\_\_\_\_ Current Meds: \_\_\_\_\_

NUTRITIONAL ASSESSMENT ☐ Adequate ☐ Inadequate ☐ Referred

SENSORY SCREEN Vision: Within normal limits? ☐ Yes ☐ No, Refer  
Hearing: Within normal limits? ☐ Yes ☐ No, Refer  
Speech: Within normal limits? ☐ Yes ☐ No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? ☐ Yes ☐ No

(If suspicious, do specific objective testing) Assessment Tool (name) \_\_\_\_\_

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? ☐ Yes ☐ No

Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) \_\_\_\_\_

T \_\_\_\_\_

P \_\_\_\_\_

R \_\_\_\_\_

## PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
2° Sexual Dev.		
Other		

## LAB/SCREENING

Tuberculin Test		
Hct./Hgb.		
Urinalysis (recommended)		

## COMMENTS, ASSESSMENT & PLAN

Follow-up needed? ☐ Yes ☐ No

## IMMUNIZATION ASSESSMENT

Did this adolescent receive all immunizations due today? ☐ Yes ☐ No  
Is there a current immunization record in the medical chart? ☐ Yes ☐ No

## ANTICIPATORY GUIDANCE

- |   |   |
|---|---|
| <input type="checkbox"/> Good health habits and self-care | <input type="checkbox"/> Dental Care            |
| <input type="checkbox"/> Good parenting practices         | <input type="checkbox"/> Nutrition              |
| <input type="checkbox"/> Counseling about sexual activity | <input type="checkbox"/> Educational activities |
| <input type="checkbox"/> Social interactions              | <input type="checkbox"/> Pregnancy prevention   |

## REFERRALS

- ☐ Dental  
☐ Behavioral Health \_\_\_\_\_  
☐ CRS  
☐ Specialty \_\_\_\_\_  
☐ WIC  
☐ Other

Next scheduled visit

Clinician Name

Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)?

☐ Yes

☐ No